BenefitMall
All together, better.

[redacted]

EMPLOYEE ELECTION FORM

THIS IS NOT AN APPLICATION FOR INSURANCE

BMLL Billing # _____
Effective Date _____
Team # _____
Carrier Group # (See Coverage Boxes)
Employer with 20 or more employees? ☐ Yes ☐ No

☑ New Hire ☐ Re-Hire ☐ COBRA/Continuation (Group Administered) ☐ Add Coverage

Last Name [redacted]	First Name [redacted]	M.I. [redacted]	Employer Goldstein and Russell	
Street Address [redacted]				Social Security Number [redacted]
City [redacted]	State [redacted]	Zip [redacted]	Gender ☐ Male ☑ Female	Date of Birth [redacted]
Home Telephone # [redacted]	Business Telephone # ( )	Marital Status ☑ S ☐ M ☐ D ☐ W	Date of Marriage	Full-Time/Re-Hire Employment Date: 4/23/18
Employee Email [redacted]			Payroll Mode (weekly, bi-weekly, etc) Monthly	
Are you actively working for the employer listed above (as defined in your insurance contract)? ☐ Yes ☑ No ☑ Full-time ☐ Part-time				Hours Worked/Week Full time
Occupation Research	Employee Class		☐ Smoker ☑ Non-Smoker	Annual Salary/Hourly Wage $26,000

MEDICAL PLAN (if offered)[1]
Carrier _____
Plan Type _____
Carrier Group # _____
☑ Employee Only
☐ Employee & Spouse
☐ Employee / Child(ren)
☐ Family
☐ Over 65 ☐ Retired ☐ Working
☐ Medicare or Complimentary to Medicare (CareFirst-Individual only; and benefit coverage only. Not eligible for HSA)
☐ Waive Coverage*

DENTAL PLAN (if offered)
Carrier _____
Plan Type _____
Carrier Group # _____
☑ Employee Only
☐ Employee & Spouse
☐ Employee / Child(ren)
☐ Family
☐ Waive Coverage*

** If enrolling in a DHMO dental plan, please complete provider information below.

VISION PLAN (if offered)
Carrier _____
Carrier Group # _____
☑ Employee Only
☐ Employee & Spouse
☐ Employee / Child(ren)
☐ Family
☐ Waive Coverage*
Not offered

☐ LTD (if offered) ☐ Waive Coverage*
☐ VOL. LTD ☐ Waive Coverage*
Carrier _____
Benefit $ _____/Mo

☐ LIFE AND AD&D (if offered)
☐ Waive Coverage*
☐ VOL LIFE $ _____
☐ SPOUSE $ _____
☐ DEP. CHILD $ _____
Carrier _____

☐ STD (if offered) ☐ Waive Coverage*
☐ VOL. STD ☐ Waive Coverage*
Plan # _____
Benefit $ _____/ Wk.
Carrier _____

*Waiver of Coverage: I certify that group insurance coverage has been offered to me and I choose to waive coverage due to:
☐ Spousal/Partner Coverage ☐ Parent Coverage ☐ Individual Coverage on Exchange ☐ Individual Coverage off Exchange ☐ Military/VA Coverage ☐ Retiree Coverage ☐ COBRA/Continuation ☐ Medicare/Medicaid ☐ No Coverage ☐ Other _____

[1]If enrolling in HMO coverage, please refer to the "Waiver of Insurance Coverage" included with this form. *By checking "Waive Coverage" you confirm that you waive coverage and have read and understand the "Waiver of Insurance Coverage" information included.

Life Insurance Beneficiary (if coverage offered) **Relationship**

Last, Full First, M.I.	Social Security Number	Birth Date	Sex	Student (Y/N)	Disabled (Y/N)	For HMO, POS, Opt-Out and Dental (if offered) Plans: Primary Care Provider Name and Carrier Assigned Provider #	Existing Patient (Y/N)
Emp [redacted]	[redacted] ☐ Smoker ☑ Non-Smoker	[redacted]	F	N	N	Medical / Dental	
Sp	☐ Smoker ☐ Non-Smoker					Medical / Dental	
Chd	☐ Smoker ☐ Non-Smoker					Medical / Dental	
Chd	☐ Smoker ☐ Non-Smoker					Medical / Dental	
Chd	☐ Smoker ☐ Non-Smoker					Medical / Dental	

OTHER/PRIOR HEALTH INSURANCE: Please note: You must complete this section if waiving or enrolling in medical coverage and your company offers Dual Coverage OR if you are currently covered under Medicare. **DC/VA GROUP COVERAGE: FOR COORDINATION OF BENEFITS, PRIOR COVERAGE INFORMATION MUST BE COMPLETED

Do you or your dependents have other/prior Health coverage with another insurer? ☐No ☐ Yes Dental? ☐No ☐ Yes *If Yes*: Effective Date:_____
☐Other ☐ Prior (indicate one or both) Carrier Name_____Policy #_____
Will this coverage be continued? ☐ Yes ☐ No *If No*: Term. Date: _____
Are you covered by Medicare? ☐No ☐ Yes Effective Date (Part A) __/__/__ Effective Date (Part B) __/__/__ Medicare #_____
Is your spouse or dependent(s) covered by Medicare?☐ No ☐ Yes Effective Date (Part A) __/__/__ Effective Date (Part B) __/__/__
Name of spouse or dependent(s) covered (if applicable): _____ Medicare #_____

CERTIFICATION: I hereby certify that I am the spouse, parent or legal guardian of the dependent(s) shown above. ***Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.***

- **Voluntary benefits may be subject to pre-existing condition exclusions (please refer to your policy for more information).**

I authorize my employer to make any necessary payroll deductions and also declare that any disability coverage in force and applied for, with respect to myself, is less than 75% of my current monthly earnings (60% for intermediate disability income [redacted]

EMPLOYEE SIGNATURE _____ DATE 4-23-18

EMPLOYER SIGNATURE/VERIFICATION _____ DATE 4/23/18

[redacted]

Rev. 11/2015